Centralized vs. Decentralized Child Mental Health Services

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One of the basic tenets of the Community Mental Health Center movement is that services should be provided in the consumers' community. Various centers across the country have attempted to do this in either a centralized or decentralized fashion. Historically, most health services have been provided centrally, a good example being the traditional general hospital with its centralized medical services. Over the years, some of these services have become decentralized to take the form of local health centers, health maintenance organizations, community clinics, etc, and now various large mental health centers are also being broken down into smaller community units. An example of each type of mental health facility is delineated here.

Centralized Services

Typical of such services is the North Central Community Mental Health Center (formerly Temple Community Mental Health Center), serving a catchment area population of over 200,000. Children and adolescents make up about a third of that total (60 to 70,000). When I was program director there we had a combined staff of about 60. The Unit included both the Mental Retardation and Child Services. Each staff member worked with patients of all ages who were emotionally-disturbed and/or retarded.

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The program was originally housed in two large buildings from which all services and staff functioned. Later, the Child Services had to be moved to a large office building where they occupied three of the ten floors.

Advantages

Location

The Child Services were located in the northeastern section of the catchment area. There was adequate transportation, and security was not a problem since the Services were one of several other programs functioning in the same building. There was also a better opportunity for staff members to get to know one another personally and professionally, and the director of the program was always available.

Coverage

Coverage was less problematic. For one thing, a child psychiatrist could be the psychiatric consultant for 20 to 30 staff members. Centralization also allowed for easier medical and secretarial staff vacation coverage.

Supervision

This was easily handled by the senior staff and the Unit director because it took so little time to go from one floor to another.

Communication

Obviously, all communication was less problematic when an entire staff was in the one building. For example, the fact that everyone could be assembled within a few hours for a meeting, facilitated communication which was helpful to all – general staff members and administrator alike.

The isolation factor was minimal since the director could get around to each Unit or staff member on a regular basis, being able, sometimes, to see most of the personnel every day.

Service

With all the service components in the same building, if a patient needed speech, pediatric, psychological, or

other evaluations, he merely had to walk down the hall or take a short elevator ride. Continuity of care was assured in this "vertical" system.

Expense

Such expenses as overhead and maintenance were minimal with all housed in the same building. Any complaints were transmitted to the Center administrator, whose office was also in the same building.

Disadvantages

During my tenure as director of the Center program the following disadvantages of centralization became apparent: (1) the difficulty for some potential patients who would have to travel long distances;[1] (2) reluctance of some patients to pass through the seemingly hostile or strange territory of the many separate neighborhoods included in the Center catchment area; and (3) scheduling problems for the mental health workers who had to travel considerable distances to make home visits. The workers (the majority) without cars had to use public transportation to save walking time. This resulted in their having to schedule, on one trip, visits to three or four families living near each other.

Decentralized Services

The Child Services of the Hahnemann Community Mental Health Center are typical of decentralized mental health services since they comprise five Outpatient Units, a partial hospitalization program for adolescents, and a 15-bed Inpatient Unit. The five Outpatient Units are scattered throughout the catchment area and each one has a Unit Director, a part-time child psychiatrist, and three or four full-time mental health staff members – social worker, mental health worker, psychologist and/or learning therapist. Each Unit also has part-time staff members and students from both the graduate and undergraduate programs of the Hahnemann Department of Mental Health Sciences. Every unit has its own budget and a part-time administrative coordinator. Also, each unit handles its own patient intake, manages its own cases, and is directly responsible to the chief of the Child Mental Health Program.

Advantages

The most obvious is the convenience of proximity of services for all community people, including those in public and parochial schools located in each of the sub-catchment areas.

Another advantage is that each Unit Director is more autonomous and has fewer restrictions as to the overall operation of his Unit. The Director of Child Services makes his rounds on a regular basis, visiting each of the Units and participating in their staff meetings. Once a week, all Unit Directors attend a centralized administrative meeting conducted by the chief of Child Services.

Disadvantages

Housing Problems

Each Outpatient Unit is housed separately so there are often individual lease arrangements and each facility must take care of its own maintenance.

Staffing and Communication Difficulties

No Unit has more than eight full-time staff members. Typical complaints are about a constant feeling of isolation, particularly for the Units farther from the centralized administration building.[2] There are often inordinate delays in mail pickup and in overall communication. Since most of the units have just one secretary, if this secretary is absent a temporary person must be hired. This is expensive with very few temporaries being that familiar with team functioning, so the administrative process slows up.

Administrative Problems

With Units separate from central administration, it is very difficult for the Director to get to know staff members well, either professionally or personally. If he has only a superficial impression of their clinical ability, he must delegate more administrative and clinical responsibility to individual Unit Directors. Also, duplication of staff occurs because each Unit must have its own child psychiatric consultant and other mental health workers. Several more people must be hired, usually on a part-time basis.

Continuity of Care

With the Units so widely separated from each other (in travel time if not in actual distance) there are occasional problems of continuity of care.

Conclusions

It is very difficult to know which is best – centralized or decentralized service. Each arrangement has strengths and weaknesses. Variables to be considered are (1) the size of the catchment area, (2) the availability of mass transportation, (3) the size of the operating budget, (4) the wishes of community residents, and (5) other factors, such as political ones, which have not been mentioned.

In any case, it is extremely important when starting towards decentralization to consider all of the above, remembering that political factors may well have more significance than anything else.

Although I did not suggest needs-assessment or some other type of evaluation to help determine whether, in fact, decentralized service would be the more feasible one, the results of such studies should be taken into serious consideration before any attempt at change is made.[3]

Summary

We have attempted herein to contrast the functioning of centralized (vertical) and decentralized (horizontal) mental health service, pointing out advantages and the disadvantages of each as we see them. We now re-emphasize the need for careful assessment and planning before a decision on one particular administrative model is made.

Literature Cited

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